

Additional Medical Information for Children Aged 5 to 16 Years

(Please complete in BLOCK CAPITALS or circle where appropriate)

1. Child's Registration Details (Continued)

Date: / /

Surname:

Forename(s):

Place of Birth:

Date of Birth: / /

Birth Weight:

Current School:

Name & Address of Person/Guardian with Parental Responsibility:

Relationship:

Their 'Phone No:

2. Child's Medical History

Please confirm if your child is allergic to any substances?

Yes / No

If yes, please give details:

Has your child ever suffered from the following?:

Asthma	Yes / No	Measles	Yes / No
Chickenpox	Yes / No	Mumps	Yes / No
Fits	Yes / No	Whooping Cough	Yes / No
German Measles	Yes / No		

Has your child had any serious illnesses or accidents?

Yes / No

If yes, please give details:

Has your child had any hospital admissions?

Yes / No

If yes, please give details:

Is there any history of Fits/Epilepsy in the child's parents or siblings?

Yes / No

3. Child's Immunisation Details

1st DTP (Pertussis/Diphtheria/Tetanus/Polio) Yes / No

2nd DTP (Pertussis/Diphtheria/Tetanus/Polio) Yes / No

3rd DTP (Pertussis/Diphtheria/Tetanus/Polio) Yes / No

MMR (Measles/Mumps/Rubella) Yes / No

Pre-School Booster Yes / No

Rubella Booster (Girls Only) Yes / No

BCG Yes / No

Tetanus Booster Yes / No

Meningitis C Yes / No